

**Preconception counseling assessment form\***  
(To be completed by patient)

Name \_\_\_\_\_

Date \_\_\_\_\_

If you're a woman of child-bearing age, please answer the following questions. You should plan to discuss this information with your doctor or health care provider during your next visit.

	Yes**	No	Unsure
Will you be trying to get pregnant within the next year?			
Do you think you are overweight or underweight?			
Do you eat less than 3 meals per day?			
Do you eat less than 5 fruit / vegetable servings per day?			
Are you on a special diet? (vegetarian, weight loss, diabetic, lactose-free, low fat, etc.)			
Do you use caffeine supplements or drink caffeine beverages? (coffee, pop, tea)			
Do you smoke or use tobacco products?			
Do you drink alcohol?			
Do you use street or recreational drugs? (cocaine, speed, marijuana, etc.)			
Do you use any prescription or over-the-counter drugs?			
Have you had a urine, bladder, or kidney infection in the last 3 years?			
Have you had Chicken Pox?			
Have you had a flu shot this year?			
Are you up-to-date on your immunizations?			
Are you aware of the danger of toxoplasmosis and how it is transmitted? (changing cat litter, followed by food preparation)			
Are you exposed to chemicals, radiation, or infections at work? (toxic fumes, lead exposure, lab work, daycare, radiation from x-rays, etc.)			
Are you currently taking a daily vitamin with folic acid? (Note: Women of childbearing age should take a daily vitamin with 0.4 mg of folic acid to prevent birth defects.)			
Have you ever been physically, emotionally or sexually abused?			
Do you live with someone who is abusive?			

Do you have a family history of birth defects or hereditary disorders?			
Have you lost 3+ pregnancies before 14 weeks due to miscarriage or abortion?			
Have you lost a pregnancy after 14 weeks for genetic or unknown reasons?			
Have you ever been tested for HIV, Chlamydia or other sexually transmitted infections?			
Have you ever had sex? (vaginal or oral)			
Are you on any kind of birth control?			
If you have sex, do you use a condom <b>every</b> time?			
Do you have diabetes, asthma, high blood pressure, high cholesterol, a thyroid disorder, an oral disease, Hepatitis B, history of blood clots, or sickle cell anemia? Other: _____			
Do you have a history of depression?			

\* Adapted from the Institute for Clinical Systems Improvement (ICSI), ICSI Health Care Guideline, August 2006. ([www.icsi.org](http://www.icsi.org))

\*\* If you answer “yes” to any of these questions, you may want to ask your doctor for preconception counseling. Be sure to ask lots of questions and request any educational materials.